GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

HEALTH PROFESSIONAL
LICENSING ADMINISTRATION

CHARACTER REFERENCE FORM

_____
APPLICANT'S NAME

_____

_____
APPLICANT'S ADDRESS

Dear Sir/Madam

The applicant whose name and address appear above has applied for a license to practice as a Physician Assistant in the District of Columbia and lists you as a reference for his/her moral character and professional experience

Please complete and return this form to the address below. Your prompt attention to this request will greatly assist the Advisory Committee on Physician Assistants when considering the applicant for licensure. Your reply will be considered as confidential information by the Advisory Committee.

Health Professional Licensing Administration
D.C. Department of Health
1st Floor
64 New York Avenue, NE
Washington, DC 20002

I hereby certify that since (date)_____, I have been closely associated with _____, residing in _____ as to be able to intellegently express an opinion as to his/her character, mental condition and habits, and that to the best of my knowledge and belief, he/she is of good moral character and free from mental defects and drug habits that are liable to interfere with the proper practice as a Physician Assistant.

REMARKS:_____

_____

_____ _____
Name (Please Print or Type) Signature/Title

_____
Address

TO BE COMPLETED BY PHYSICIAN ASSISTANT APPLICANT

I Hear by certify that I have read and understand the contents of the Standard job description, Chapter 49, Title 17, DCMR, and the Health Occupations Revision Act, 1986 and agree to observe the requirements for practice as a Physician Assistant set forth in those Documents.

Date _____

_____

Signature of Applicant/Licensee

TO BE COMPLETED BY SUPERVISING PHYSICIAN

I Hear by certify that I have read and understand the contents of the Standard job description, Chapter 49, Title 17, DCMR, and the Health Occupations Revision Act, 1986 and agree to observe the requirements for supervising the practice of a physician assistant set forth in those documents.

Date _____

_____

Signature of Licensee/License number

TO BE COMPLETED BY BACK-UP SUPERVISING PHYSICIAN

I Hear by certify that I have read and understand the contents of the Standard Job description, Chapter 49, Title 17, DCMR, and the Health Occupations Revision Act, 1986 and agree to observe the requirements for supervising the practice of a physician assistant set forth in those documents.

Date _____

_____

Signature of Licensee/License number